

FILED JUN 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16685

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5442 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <b>GASCONADE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>GASCONADE</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RICHLAND TWP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>0370</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>11 mi. W. of HERMANN</b>			Length of stay in 1b <b>56 yrs</b>		d. STREET ADDRESS (If outside, give location) <b>11 mi. W. of HERMANN</b>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>MARTIN</b> Last <b>KELLER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>27</b> Year <b>1957</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 21-1900</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Month <input checked="" type="checkbox"/> Days <input checked="" type="checkbox"/> Hours <input checked="" type="checkbox"/> Min. <input checked="" type="checkbox"/>	IF UNDER 24 HRS. Hour <input checked="" type="checkbox"/> Min. <input checked="" type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <b>FARMER</b>			100. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and state or country) <b>HERMANN RFD Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>ADOLF KELLER</b>				14. MOTHER'S MAIDEN NAME <b>CONRADINA KLICK</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>491-36-5826</b>		17. INFORMANT Address <b>RFD</b> <b>Mrs LORENCE KELLER HERMANN Mo</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Sarcinoma</b> DUE TO (b) <b>Melanoma</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b> <b>2 1/2 yrs.</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <b>May 17, 1957</b> , to <b>May 27, 1957</b> and last saw <del>him</del> <b>him</b> alive on <b>5/24/57</b> Death occurred at <b>9:45 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>W. O. 2</b>				22b. ADDRESS <b>Hermann, Mo</b>		22c. DATE SIGNED <b>5/28/57</b>		
23a. BURIAL, CREATION, REMOVAL (Specify)		23b. DATE <b>5/30/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HERMANN RFD. Mo</b>			
24. FUNERAL DIRECTOR ADDRESS <b>HUGO H. BLUMER HERMANN Mo</b>			25. DATE RECD. BY LOCAL REG. <b>5/30/1957</b>		26. REGISTRAR'S SIGNATURE <b>Delma Yerkes</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

517

VS  
SEP 23 1958

FEB 27 1958

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ..... Student Embalmer No. ....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 316

P. O. Address.....  
Herrmann

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.